Simple strategies for complex behaviours – Do you know your ABCs?

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Introduction

• Increasingly aged population = Increase in population affected by dementia

• Behavioural & psychological symptoms of dementia (BPSD) affect up to 90% of people with dementia

• Evidence suggests that these symptoms are poorly understood
Yesterday

• Behavioural & psychological symptoms have traditionally been called ‘challenging behaviours’

• Negative connotations the term evoked influenced health professionals to view the people who display them as problem patients
Today

• Starting to see the behaviours for what they are: Symptoms of an illness

• Beginning to see a change in practice to an increasingly evidence based approach

• Research has identified a need for training on practical strategies to understand these symptoms & on components of care required to achieve ‘best practice.’
Today’s tools

• A survey that facilities can use as part of their QI process to compare current practice with best practice

• ABC framework for managing BPSD
Tomorrow

• Once health professionals are shown how the ABC framework can be implemented into practice they can apply it to any scenario

• Facilities provide a positive environment where staff implement simple but effective evidence based practice to care for people with BPSD
Background

• Regional Dementia Management Strategy (RDMS)

• 'Building the capacity of rural acute and residential aged care facilities to manage challenging behaviour in dementia' project

• Both funded by Department of Human Services
Loddon Mallee Region in Victoria

Australia

Kilometers

0 50 100
Regional Dementia Management Strategy (RDMS)

• Outlines a pathway for dementia care from the community, through the acute setting and back into the community or residential care

• Provides decision trees, checklists and guidelines for dementia assessment and management at each stage along the care continuum
Regional Dementia Management Strategy - Pathway Overview

Community Health:
- Ambulance checklist
- Police checklist
- Primary care assessment pathway for GPs
- HACC checklist
- Day Centre checklist

Emergency Department:
- Emergency department pathway for care of the 'confused older person'

Public Awareness Information:
- Information brochure
- Promotional poster

Displayed in community health centres & GP clinics
For more information contact www.alzvic.asn.au

Health professionals information:
- Dementia information kit for HACC workers/PCAs
- Dementia information kit for Registered nurses
  Available in power point format

Residential Care:
- ABC behaviour management model overview
- ABC behaviour management model scenarios
- Specific behaviour management strategies
- Ten Top Tips for dealing with people who have dementia
- Communication strategies
- Referral protocols

Acute Hospitals:
- Barwon Health Delirium guideline
RDMS

- Carer focus groups were conducted with both informal carers (family/friends) and with formal carers (acute, subacute and residential care workers) throughout the region.

- A major theme that emerged from these focus groups was that behaviours associated with dementia are poorly understood and that the staff working in acute and residential care facilities (RCFs) are not adequately trained to deal with these behaviours.
What did we do about it?

• 'Building the capacity of rural acute and residential aged care facilities to manage challenging behaviour in dementia’ project

• Surveyed all acute & residential aged care facilities in the region:
  – Acute = 31
  – Residential aged care facilities = 71
What did we ask?

• Questions to quantify the extent of challenging behaviours and the strategies and resources with which they are managed

• Both surveys consisted of six sections:
  – Environment
  – Policies
  – Staffing
  – Staff education and training
  – Behaviour management
  – General
What did we find?

• Facilities in our region identified shortcomings in their ability to manage effectively people with BPSD

• Anecdotal evidence suggests that these shortcomings are not unique and are actually common to all facilities, both regional and metropolitan
“Is your facility able to manage people with dementia who display challenging behaviours?”

<table>
<thead>
<tr>
<th>Percentage of facilities</th>
<th>Yes</th>
<th>At times</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>0</td>
<td>0</td>
<td>75</td>
</tr>
<tr>
<td>Residential</td>
<td>0</td>
<td>0</td>
<td>50</td>
</tr>
</tbody>
</table>
“Please describe the behaviours that you are not able to manage in your facility”

![Bar graph showing the percentage of facilities dealing with various behaviours]

- Wandering absconding
- Aggression
- Inappropriate/intrusive behaviour
- ABS/de-lirium
- Self harm/risk to others
- Verbal disruption
- Falls risk
- Socially inappropriate behaviour
- General dementia
- Psychiatric illness

Legend:
- Acute
- Residential
What did we do about it?

• Focused on the main training needs of regional nurses
• Developed a ‘Train the Trainer” education program for ‘dementia champions’
• Based education on the ABC behaviour model
• Provided resources for champions to use in their own facilities
Did it work?

Average score

- Workshop 1 - July 2003
- Workshop 2 - August 2003
- 12 month update - Nov 2004
What is the ABC framework?

A way of characterising events and resultant behaviours:

- A = Activating event
- B = Behaviour
- C = Consequence

The ABC can be applied in all settings
ABC

• A behaviour in response to an activating event generates a consequence

• If the consequence is inappropriately managed, the situation may escalate & become another activating event
Preventing & Managing Aggression

A = Activating Event
To prevent aggression, follow the Ten Top Tips for dealing with people who have dementia. If aggression occurs establish the activating event, or trigger.
There is always an A.

B = Behaviour
What happened as a result of A?
Describe the actual behaviour, ie; verbal/physical aggression; weapon used (urinal, walking stick etc)

C = Consequence
What was the consequence of B?
Assess why the person was aggressive - are they unwell, in pain?
Think about appropriate referrals - GP, pain management, Geriatrician, Aged Persons Mental Health Service (APMHS)

D = Decide & Debrief
What changes do you need to make - environmental, staffing.
How can you change A to better manage B? Brainstorm!

D = De-escalate
Allow time for recovery

Immediate management strategies:
• Remove other people from danger
• Remove potential weapons
• Give the person space (stand back)
• Communicate in a calm, non-confronting way - avoid asking 'What' or 'Why' - (remember communication is 55% body language, 38% tone of voice & only 7% words)
• Encourage the person to talk about how they are feeling
• Empathise, ie: I can see you are very angry, frightened etc............
• Allow the person time to talk through their issues & establish what the problem is (try to put yourself in their shoes)

Behaviour will escalate if it's not well managed.

See specific strategies to manage aggression for ongoing management.
Activating Events

• When & where did the behaviour occur?

• What was the person doing immediately before the behaviour occurred?

• What was happening around the person at the time?
Assess environmental factors:

- Noise (eg. TV loud, music loud, staff change of shift, meal time clatter)
- Clutter (eg. Furniture, people)
- Bright lights/glare on the floor
- Mirrors
- Temperature (eg. Too hot/cold)
- Recent changes to environment (eg. Renovations, staff/resident changes)
- Does the environment provide a safe area for residents to wander around?
- Does the environment encourage independence, dignity and mobility?
- Does the environment accept the client's cultural and lifestyle habits
Assess **physical factors:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metabolic</strong></td>
<td>Hyper/Hypo thyroidism, Hypercalcemia, Hyponatremia</td>
</tr>
<tr>
<td><strong>Infections</strong></td>
<td>Urinary tract infection, pneumonia, septicaemia</td>
</tr>
<tr>
<td><strong>Traumatic</strong></td>
<td>Chronic pain, head trauma, fractures such as hip &amp; rib</td>
</tr>
<tr>
<td><strong>Systemic</strong></td>
<td>Hypoglycaemia, Vitamin B12 deficiency, folate deficiency</td>
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<tr>
<td><strong>Medications</strong></td>
<td>Sedatives, antihistamines, alcohol, polypharmacy</td>
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<tr>
<td><strong>Impaction</strong></td>
<td>Faecal</td>
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Don’t forget Delirium
Assess physical factors (cont):

• Has there been a recent change in medication?

• Does the person have:
  – Impaired vision or hearing
  – Acute illness
  – Chronic illness (eg; angina, CCF, Diabetes)
  – Chronic pain (eg; arthritis, ulcers, headaches)
  – Dehydration
  – Fatigue or physical discomfort
Assess psychological factors:

- History of psychiatric illness
- Recent loss or accumulation of losses
- Appear sad – tearful, withdrawn
- Past events – Post traumatic stress, P.O.W.
- Responding to hallucinations
Behaviour

• IPA defines BPSD as “Symptoms of disturbed perception, thought content, mood or behaviour that frequently occur in patients with dementia”.
### BPSD

<table>
<thead>
<tr>
<th>Behavioural symptoms</th>
<th>Psychological symptoms</th>
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<tbody>
<tr>
<td>Physical aggression</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Screaming</td>
<td>Depressive mood</td>
</tr>
<tr>
<td>Restlessness</td>
<td>Paranoia</td>
</tr>
<tr>
<td>Agitation</td>
<td>Hallucinations</td>
</tr>
<tr>
<td>Wandering</td>
<td>Delusions</td>
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<tr>
<td>Culturally inappropriate behaviours</td>
<td></td>
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<tr>
<td>Sexual disinhibition</td>
<td></td>
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<tr>
<td>Hoarding</td>
<td></td>
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<tr>
<td>Constant questioning</td>
<td></td>
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<tr>
<td>Cursing</td>
<td></td>
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<tr>
<td>Shadowing</td>
<td></td>
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</table>
Consequence

• What was the consequence of the behaviour for the person, staff & others?
  – Ignored
  – Reprimanded
  – Restrained
  – Sedated

• Very dependent on staff interpretation & reaction to the behaviour
Communication

- Body language: 55%
- Tone & pitch of voice: 38%
- Words we use: 7%
- Other: 38%
When reviewing the ABC with the person, their family & the care team the following questions should be posed:

• What is the actual problem & whose problem is it?
• What are the contributing factors
• How can we increase our understanding of this? Brainstorm ideas to come up with an effective individual management plan
• Where to from here? Is referral to a specialist service required?
PREVENTING & MANAGING CATASTROPHIC REACTIONS

What is a Catastrophic Reaction?
Catastrophic reactions may be related to past events, unhappy memories, or tasks & communication or instructions being too complicated. Catastrophic reactions are inappropriate emotional outbursts due to the person’s inability to cope with real or imagined events.

A = Activating Event
Establish the trigger: What happened? Who was involved? When did it occur? Who's problem is it?

Debrief and Decide
• Develop a management plan that prevents them being overwhelmed by complicated tasks or unpleasant memories
• Always check for symptoms of delirium.

Immediate management strategies:
• Remove distractions
• Remain calm and relaxed
• Establish non-threatening eye contact
• Use the person's name
• Be respectful & reassuring
• Speak clearly in short sentences
• Do not patronise
• Avoid the use of restraint

Stop! Decision Point!
Observe body language for signs of frustration, fear, anger, distress or confusion

See specific strategies for ongoing management of catastrophic reactions.

C = Consequences
• Adapting your own body language and non-verbal communication to the residents symptoms will assist them to recover from the catastrophic reaction; eg reassure them if frightened
• Remove any distractions
• Use Positive communication strategies (see specific communication strategies)

B = Behaviour
People with brain damage are easily overwhelmed & respond with excessive emotions & behaviours. eg: panic attack/aggression
Scenario 1.

81 year old Mrs Betty Baxter has recently been diagnosed with dementia and has moved to Shady Haven Nursing Home. She is well known around the town as a forthright (some might even say argumentative) lady, and the local CWA, and the regional Red Cross all breathed a sigh of relief when she resigned from the committee.

Mrs (“I don’t like being called Betty”) Baxter has many medical problems and her medications were recently changed, with some doses having a higher dose with less tablets, due to her pharmacist recommending a cheaper brand.
Scenario 1 (cont.)

• Yesterday she refused her heart medication and became quite abusive and threw the glass of water, when the agency nurse tried to insist that she take the medication as prescribed. When the nurse politely but firmly reminded Betty, that this was not appropriate behaviour, Mrs Baxter slapped the nurse on the face.

• Today her sister has come to visit and Betty will not allow her to come in to her room. Attempts by her sister to clarify the situation lead to verbal abuse and incoherent muttering.
What are the issues?

• For Betty?
• For the staff?
• Behaviour that is misunderstood and managed inappropriately may escalate.

• How would we apply the ABC framework?

A = Activating Event
   (what was the trigger)

B = Behaviour
   (what behaviour resulted)

C = Consequence
   What was the consequence
Scenario 2

Mr Cyril Bogg is a retired security guard who has lived in an aged care facility for six months.

Staff have become increasingly concerned that over the last few weeks, Cyril has been wandering in to peoples rooms at night. He is becoming increasingly intrusive & has frightened several elderly woman after they awoke to find him in their room.
Scenario 2 (Cont.)

- Staff are concerned at his manipulative behaviour as he is not intrusive through the day, and are worried that he has ulterior motives.
- Attempts to get Mr Bloggs to return to his room are unsuccessful & usually result in a verbal abuse. The GP has just commenced night sedation.
What are the issues?

• For Cyril?
• For the staff?

• Behaviour that is misunderstood and managed inappropriately may escalate.

• How would we apply the ABC framework?

A = Activating Event
(what was the trigger)

B = Behaviour
(what behaviour resulted)

C = Consequence
What was the consequence
What we learnt

- Do not assume basic level of knowledge

- Sustainable - focus on creating change in attitudes & culture of care

- Build the capacity at a local level

- Train the trainer - develop peer support
TEN TOP TIPS FOR DEALING WITH PEOPLE WHO HAVE DEMENTIA
SOURCE: REGIONAL DEMENTIA MANAGEMENT STRATEGY

1. STOP!! Think about what you are about to do and consider the best way to do it.
   PLAN & EXPLAIN!! - Who you are; What you want to do; Why.

2. SMILE!! The person who takes their cue from you will mirror your relaxed and positive body language and tone of voice.

3. GO SLOW!! You have a lot to do and you are in a hurry but the person isn’t. How would you feel if someone came into your bedroom, pulled back your blankets and started pulling you out of bed without even giving you time to wake up properly?

4. GO AWAY!! If the person is “resistive or aggressive” but is not causing harm to themselves or others, leave them alone. Give them time to settle down and reapproach later.

5. GIVE THEM SPACE!! Any activity that involves invasion of personal space increases the risk of assault and aggression. Every time you provide care for a person you are invading their space!

6. STAND ASIDE!! Always provide care from the side not the front of the person where you are an easy target to hit, kick etc.

7. DISTRACT THEM!! Talk to the person about things they enjoyed in the past and give them a face washer or something to hold while you are providing care.

8. KEEP IT QUIET!! Check noise level and reduce it. Turn off the radio and TV!

9. DON’T ARGUE!! They are right and you are wrong! The demented brain tells the person they can’t be wrong.

10. BRAINSTORM & DEBRIEF!! How can you and your team best meet the physical, environmental and psychological needs of the people in your care?
ABC Resources

• Ten Top Tips for Dealing with People who have Dementia

• Do’s & Don’ts of Communication

• ABC Scenarios

• Specific strategies